DOCUMENT RESUME

ED 449 952 RC 022 815

TITLE	Rural Health: The Story of Outreach. A Program of Cooperation in Health Care.
INSTITUTION	Health Resources and Services Administration (DHHS), Rockville, MD. Office of Rural Health Policy.; National Rural Health Association, Kansas City, MO.
PUB DATE	1993-00-00
NOTE	49p.; Photographs may not reproduce adequately.
AVAILABLE FROM	Health Resources and Services Administration, Parklawn Building, Room 9-05, 5600 Fishers Lane, Rockville, MD 20857, Tel: 888-ASK-HRSA, Web site: http://www.ask.hrsa.gov/detail.cfm?id=ORHP00037.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Agency Cooperation; Allied Health Occupations Education; Child Health; Elementary Secondary Education; Federal Aid; Geographic Isolation; *Health Education; *Health Services; Medical Education; Mental Health Programs; *Outreach Programs; Prenatal Care; Program Descriptions; Public Health; *Rural Areas; School Community Relationship
IDENTIFIERS	Access to Health Care; Telemedicine

ABSTRACT

Rural Health Outreach is a federal program of demonstration grants designed to encourage organizations to cooperate in delivering health care services to rural Americans. Thirteen programs utilizing innovative collaborations between state agencies, schools, nonprofit organizations, hospitals, volunteers, and the private sector are described a year into their work. On Virginia's Delmarva Peninsula, check-ups were provided to middle school students at school. In North Dakota, ambulance volunteers received training. A consortium of community mental health centers in 13 Oregon counties accessed help from specialists via satellite. Mobile prenatal care was provided in two northwestern Pennsylvania counties. Alaska Natives were trained to be physician assistants in their rural villages. In- and out-patient hospice services were established in Grundy County, Iowa. An Ohio school district provided mental health counseling to students and families at school or home. A family planning service was upgraded to provide full-time primary care service at two sites on Oahu (Hawaii). Financial counseling and aid was provided at public health sites throughout western Wisconsin. A new telecommunications network enabled physicians at Maine health centers to update their learning and consult one another. Native American culture was incorporated into mental health therapy addressing high alcoholism and school dropout rates in a New Mexico town. A northeast Oklahoma consortium coordinated and complemented the region's elderly services. Health education programs in schools combated teen pregnancy and a new van transported clients to clinics for prenatal care in two Alabama counties. (TD)

Reproductions supplied by EDRS are the best that can be made
from the original document.

RC

ED 449 952

BEST COPY AVAILABLE

RURAL HEALTH

THE STORY OF OUTREACH

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

A program of cooperation in health care

Administered by the Federal Office of Rural Health Policy

Health Resources and Services Administration, DHHS

Produced by the National Rural Health Association

BEST COPY AVAILABLE

RC U228 15

On May 8, 1991, over 500 rural communities in almost every state of the union responded to a challenge from Congress to reach out inventively to their own people with badly needed health care.

Today, 100 communities are making use of Rural Health Outreach Grants to show what innovation and collaboration can accomplish.

Photo: U.S. Department of Agriculture

BEST COPY AVAILABLE

6

7

WHY RURAL?

Nearly one fourth of all Americans are rural residents. And because of where they live, they often lack adequate health care.

Across prairies, in hamlets, on islands, in woodlands, hollows, and on farmlands, thousands of Americans are without physicians, nurses, counselors, hospitals, even emergency help.

More than 1,400 rural communities in virtually every state of the union suffer critical shortages of health care providers.

Distance, with a lack of public transportation, rough terrain, or unpredictable weather, is one of the greatest obstacles to care for rural citizens, especially the elderly.

For still others, language and cultural differences add barriers.

Rural Americans often lack the financial resources to prevent or overcome these problems. Thus, many go without needed health care, especially preventive care. Children fail to receive immunizations and routine checkups.

Neglected illnesses and injuries grow into expensive hospitalizations. Emotional problems and substance abuse go undetected and untreated.

Federal programs have been in place for several years to address these problems. Community health centers and migrant health centers have been established, along with higher reimbursements for rural health clinics under federal insurance. Also, the National Health Service Corps has provided a range of health professionals for periods of service in many "shortage" areas.

BEST COPY AVAILABLE

Despite these efforts, many rural residents, especially the poor and near poor, are not receiving essential care.

"By and large (existing programs) do not cooperate and coordinate to reach these forgotten populations in rural America."

With these words, Congress appropriated $18.3 million in funds for *Rural Health Outreach*, a program of demonstration grants.

Through the new Rural Health Outreach Program, Congress invited rural organizations to collaborate and form consortiums that could pull together the scarce drawstrings of support to deliver needed health care.

By May of '91, over 500 communities responded to the grant announcement with ideas and proposals from clinics, civic groups, local health departments, hospitals and others.

A hundred demonstration projects were funded in '91. Approximately 15 - 20 more grants will be awarded by the end of fiscal '92.

Following are brief accounts of 13 Rural Health Outreach demonstration projects across the country a year into their work. They represent a variety of problems and demonstrate a wide range of strategies:

- They offer basic health care where none was available...
- They bring care to pregnant mothers and babies to combat infant deaths...
- They bring emotional support and counseling to those who are isolated.
- They build emergency medical services...
- They train local health professionals, and support those who are already there.

Photo: U.S. Department of Agriculture

All capitalize on local resources. Some are unique. Many adapt new ideas.

All inform.

Bringing the check-ups to the children

VIRGINIA

"They have medical conditions that have never been taken care of — they've been sick for years and years."

Pediatrician Hans Brehm used to have a private practice in the comfortable Pocono region of Pennsylvania where he seldom needed to make house calls. Now in semi-retirement, he lives on Virginia's isolated Delmarva Peninsula shore where he makes school calls.

He is part of an Outreach-sponsored project that plans to reach some 600 school children who rarely see a physician — about 30 percent of the middle-school population in Accomack and Northampton counties.

Since April, Dr. Brehm and two nurses, who also work as case managers, travel to the six middle schools in the area to examine and treat an average of 25 students each day. The project is a joint venture by Virginia's departments of health, mental health, and social services, both counties' school districts, and the Eastern Shore Rural Health System, a community health center in Onancock.

"A doctor was a foreign figure to these children," says project director Sister Catherine Dever. Most, she says, are on Medicaid or are uninsured.

Eastern Shore spearheaded the consortium effort when it discovered through surveys that many of the area's children, ages 9-13, had stopped receiving health care once they reached school age.

For youngsters who are uninsured or on Medicaid, preventive care was a new experience. Of the 200 children seen in the first three months, fourteen percent showed up with impacted ears that Dr. Brehm was able to treat immediately.

"I'm flabbergasted at what I see," says Dr. Brehm. "They have medical conditions that have never been taken care of — they've been sick for years and years."

"Prevention is the message we want to give to the students and their families," says Sister Catherine. School officials who worried at first that on-site examinations would interrupt classwork, now say the program has reduced disciplinary problems and absenteeism.

Program leaders say they based the new school primary care program on a Scandinavian model of delivery that puts the care where the children are. A 'round-trip' visit to Dr. Brehm from the classroom takes 15 or 20 minutes, involves no transportation problems, and saves hourly wages for working parents, according to Sister Catherine.

Capitalizing on the school site in this isolated section of Virginia, the Eastern Shore program conducts screening, vision and hearing tests, and physical exams. Dr. Brehm also treats acute and chronic conditions, and administers prescriptions and immunizations.

Students are also referred to specialists and mental health and social service agencies. By the fall of '92, Eastern Shore's team of visitors will also include a mental health counselor, says Sister Catherine.

Supporting volunteers on the front lines

Spokesman Dale Severson quickly sums up the rural vulnerabilities:

North Dakota is "550 miles wide and 350 miles deep." Fewer than a third of its 650,000 people live in the Western two-thirds of the state — "where the Bad Lands, Lake Sakakawea and all the tourists are." Agriculture is the state's number one industryand the nation's most hazardous occupation. Yet there is not enough emergency medical service and enough training to go around.

"We don't have the tax base to support it," says Severson. He is president of the North Dakota Association of Emergency Medical Technicians.

Adding to the worry is the fact that state law does not require more than "Advanced First Aid" training for certification of emergency medical personnel. Severson calculates that almost a quarter of North Dakota's volunteers are badly underprepared. AFA., he says, does not even qualify someone to administer oxygen or take blood pressure.

Through an Outreach grant, however, Severson's association, along with two state training societies and the state health department, are collaborating on a sweeping program to visit each of 119 volunteer ambulance services in North Dakota and bring advanced and refresher training to the state's 3,250 volunteers.

The first priority, according to Severson, is the group of 750 volunteers who have only first aid training. Some 359 of them have already been enrolled in the first level of training, called "basic," which is required for certification as an emergency medical technician, or EMT.

Over a three-year period, the consortium plans to provide Advanced Life Support training, or ALS, to the state's more than 2,500 volunteers currently certified as EMTs. (Second and third-level certification for EMTs is regarded as advanced life support.)

The consortium includes the IC Society in North Dakota, an association of instructors and coordinators who teach certification classes and arrange for specialists, props and actors in the re-enactment of emergency scenes. Also in the consortium is the ALS Society of paramedics who test and recommend equipment. The consortium has purchased seven sets of training equipment.

To select priority sites for the first training visits, the state health department's Division of Emergency Health Services pinpointed locales with high emergency rates — farms and open roads, including railroad crossings.

"You can be driving for miles and not see anything — not a tree anywhere," says Severson. "There's a track you've been over a thousand times and never seen a train. Then it's there. Ruralness does that."

Bringing the training and the equipment right to the community is the linchpin of the plan, according to Severson. Not only will it nudge the first-aid people into more training, it will help maintain North Dakota's seasoned personnel.

Attrition for rural volunteers is high, in part, because recertification every two years has required volunteers to drive long distances on weeknights for refresher training.

Also, rural work is uniquely stressful. "Usually in a rural emergency it's somebody you know," says Severson. In a community of 1,500 people, we know everybody."

To attract new volunteers and win broad public support, the consortium has developed public service announcements.

"We want to enthuse people," says Severson. "Tell them, 'Hey, we've chosen to live here. We need your help to maintain our way of life. If we lose more hospitals and rural medicine changes, the ambulance service in some places could be the only medical professonals around."

NORTH DAKOTA

"If we lose more hospitals and rural medicine changes, the ambulance service in some places could be the only medical professionals around."

Consultations by telecommunication

OREGON

"When you only have seven percent of the population, you are going to need to collaborate to get the best kind of service into your region."

As the consultative power of telemedicine reveals itself in the long distance transmission of X-rays, EKGs, and live video views of patients, rural eastern Oregon is exploring its potential in the mental health field.

Today, a consortium of community mental health centers in 13 of Oregon's rural counties has hooked into a satellite transmission system that permits them to get case management help from mental health specialists in urban Portland and Pendleton.

Using Outreach funds and capitalizing on Oregon's already-existing satellite equipment for distance education, the Eastern Oregon Human Services Consortium has created "RODEO-NET." The network has made it possible, among other things, to reduce the number of rural patients transported back and forth on an eight-hour trip to the Oregon state (psychiatric) hospital for evaluations.

Now, when they need to, social workers, mental health therapists and other practitioners scattered throughout 45,000 square miles of rural eastern Oregon can confer with psychiatrists, psychologists and nurse practitioners working at the University of Oregon's Health Science Center in Portland or at the Eastern Oregon Psychiatric Center in Pendleton. Most importantly, with television transmission, they can include their clients in the conference.

The latter group of providers are those who can offer medical interventions and assessments for hospital admissions or discharges, and admission interviews to group homes — but who are scarce in rural areas.

"Often, the general practitioner in a rural community is the mental health system," says consortium executive director, Douglas Overlock.

The new RODEO-NET uses equipment located at seven community studios around the state — at schools, hospitals, community colleges, school district buildings, "any place that will allow community access," says Cathy Britain, project manager.

The Eastern Oregon consortium is based in La Grande. The project works collaboratively with Eastern Oregon State College, Northeast Oregon Area Health Education Center, and state health agencies such as the Mental Health Division, Children's Services Division, and Senior and Disabled Services Division.

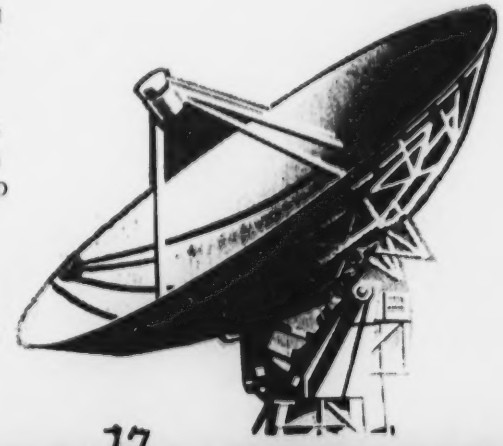
To facilitate collaboration throughout the network, the consortium is working to add computers. "Computer conferencing frees us from having a meeting at only one point in time," says Britain. "If we could put a computer on the desk, we would have a nice follow-up capacity and a real solid system for linking our folks."

Continuing education is also part of the plan. In collaboration with Portland State University, the project is developing a mental health curriculum for the network users.

Master's and doctoral degrees in social work are required for reimbursement under Medicaid and Medicare, and therefore, important for serving poor rural clients.

Britain expects the network to reduce isolation and empower a variety of community service workers. "If you are the only nurse practitioner in Berns, and your closest colleague is 200 miles away, you need to share ideas," she says.

Empowerment was also a concept behind the consortium. "Sometimes the state seems to stop at the Cascades," says Britain. "When you only have seven percent of the population, you are going to need to collaborate in order to get the best kind of service into your region."



BEST COPY AVAILABLE

Driving the clinic to the patient

PENNSYLVANIA

"You wouldn't believe the cow paths we've had this thing on," says Gail Stewart, administrative assistant for an outreach clinic on wheels that seeks out pregnant women in an economically depressed area of northwestern Pennsylvania.

Since May of '92, low-income women living in Venango and Forest counties no longer have to travel up to 40 miles to a busy clinic in Seneca to receive prenatal care. (Many had stopped trying.)

Today they can dial an 800-number to get information and schedule a local visit from the mobile clinic, as the result of the program called "A Caring Start." The staff will arrange a site ideally within walking distance — a church parking lot, a driveway — to park the clinic so that as many women as possible can take advantage of a visit.

Developed with Outreach funds by the Northwest Pennsylvania Regional Planning and Development Commission, the mobile clinic is the center of a regional effort to bring services to an area that suffered an acute shortage of obstetrical providers.

Other project partners have included the state health department, the local social service and welfare departments, a Venango County vocational school, and the Family Health Council, Inc., which operates a family planning and prenatal clinic in Seneca.

As of late August of '92, the consortium-sponsored clinic has traveled to 18 sites, delivering services to 35 women. The goal is to serve 49 prenatal clients during the program's first year.

"It gives you a good feeling to help these women," says project director Shelly Carll. She says the "personal touch" can be crucial at times: "One woman we saw recently lost her husband in a car accident. She was able to bring her little girl with her into the clinic and not have to worry about leaving her to a sitter."

While the grant funds paid for the mobile unit and medical equipment, the Family Health Council provides for the registered nurse and nurse practitioner on board. Four private physicians (three are newly-recruited to the area) offer medical backup and see patients periodically at the clinic. The local hospital handles all deliveries.

To ease the shortage of providers in the counties, the project has recruited a perinatal nurse specialist who will enroll in a midwife certification program.

Project staff are also considering a plan to recruit a pediatrician or a pediatric nurse practitioner to the area to help with the area's overwhelming case load. (There are currently only three pediatricians in a two-county area of 65,000 people.) Consortium members have additional plans for the mobile medical facility. The local social services agency, for example, is planning its use for nutritional outreach under the WIC program — the Department of Agriculture's supplemental food program for women, infants and children.

The mobile clinic is already generating referrals to consortium programs, says Stewart. "Family planning is getting nine new patients a week."

...the mobile clinic is the center of a regional effort to bring services to an area that's suffered an acute shortage of obstetrical providers.

BEST COPY AVAILABLE

Training villagers who want to stay

ALASKA

"We're ahead of all expectations — especially as far as responses from the community health aides."

Scattered throughout the vast wilderness of Alaska are 171 isolated native villages, most of which have no doctor. The closest physician or hospital may be hundreds of miles away by small plane and totally inaccessible during the long periods of bad weather.

Native health aides, trained by the Indian Health Service, must make do, meanwhile, since few primary care providers from other areas are willing to move to the remote villages.

Until recently, the prospect of bridging this medical chasm was bleak. Any upgrade in training for the native health aides would have meant relocating out of state to Seattle — a cultural and geographical leap that few Alaskan Natives or Native Americans have wanted to make.

By September of '93, however, several villagers will be able to train closer to home, in Sitka — the result of a new Outreach-sponsored strategy to train Alaskan Natives in their own back yards as physician assistants.

The project is the collaborative work of the Sitka-based University of Alaska Southeast, the Southeast Alaska Regional Health Corporation — one of 12 regional native health corporations in the state — and the University of Washington MEDEX program.

The physician assistant program will start up with 12 students in the fall of '93. So far, some 280 people have contacted the project office to begin a two-step process of screening and interviewing — a positive response by any measure, says project director Bill Burton.

"We're ahead of all expectations — especially as far as responses from the community health aides," he says. While the program is not exclusively for Alaskan villagers, it's anticipated that Alaskan Natives will comprise a major portion of the candidates.

The program will eventually have clinical sites in rural Alaska so that students, in their second year of training, will have rural rotations. Six Alaskan students currently in their first year of training at the University of Washington in Seattle will be able to join the rural rotations in their second year.

Meanwhile, the new PA applicants are receiving advice about financial aid and coursework they may need in order to qualify.

Burton says over half of the community health aides now applying for the program are virtually qualified for admission.

The University of Alaska is also promoting candidacies by offering a dozen preparatory courses at village sites through its "distance-education" program of videos and teleconferencing.

Newspaper articles and the native health corporation network have been used to advertise the new Sitka PA program. Still, a tremendous amount of information has moved by word of mouth, according to Burton, in this state where news about closing-the-distance travels fast.

Replacing isolation with a hospice

Once each week, five team members of a new hospice program in rural Grundy County Iowa meet to confer. A nurse, a social worker, a physician, pharmacist and chaplain — they form the headwaters for a stream of volunteer care that in the past three months has helped sustain 16 Grundy County families coping with terminal illness.

Funded by a Rural Health Outreach grant, the program was the inspiration of a number of Grundy County agencies concerned over a lack of organized support for terminal patients and their families in this farming region.

"When people are dying, neighbors and acquaintances who might normally visit don't come anymore," says Barbara Vos, hospice project director and Director of Patient Care Services at Grundy County Memorial Hospital. The attending relatives or friends who are left behind begin to sink under the weight of nursing chores, daily responsibilities, and grief.

"Country people are just as vulnerable to this isolation as city people," says Vos, "especially the elderly whose children have long ago moved away."

A Grundy County committee formed from the hospital, the health department, and volunteer organizations had begun to plan for a hospice program in 1989. But without any local industry to contribute money, launching a hospice in a rural community presented distinct problems of start-up funding.

Foundation and corporate benefactors aren't readily available to small communities, according to Vos. Many farmers in the county pay for health insurance, she says, "but that money is in DeMoines."

"The reality is that health care resources here are about as scarce as in the inner city," she says. "If it weren't for things like Outreach, we couldn't do it."

Local residents added $5,000 of their own money to Rural Outreach funds in October of '92 to create the hospital-based program. The nurse and social worker are on the hospital staff. The physician, pharmacist, chaplain, and volunteers donate their time.

The Grundy County Nursing Services contributed registered nurse time and helped arrange for home health aide services. Volunteers in Action helped recruit and train the lay volunteers who visit patients' homes to offer assistance, respite, and emotional support.

Meanwhile, a small renovation at the hospital created room for inpatient hospice care and some office space.

Cedar Valley Hospice, a Medicare-certified hospice in Waterloo some 30 miles away, originally provided administrative and procedural guidance to the new hospice. When its start-up funding ends in September, Grundy County Hospice hopes to have Medicare certification, which will provide a source of reimbursement.

Director Vos predicts the program will survive, given its support in the community. "It has really made a difference in a lot of people's lives," she says.

HOSPICE

A SPECIAL KIND OF CARING

IOWA

"The reality is that health care resources here are about as scarce as in the inner city."

BEST COPY AVAILABLE

Bringing mental health to school

OHIO

"The children and youth are being hit especially hard ...and the schools are often the social locus of that impact."

In the past, the busy nurses at the junior and senior high in Fremont, Ohio could only worry and wonder about the needs of some chronically absent students. Today they can send a community nurse to those students' homes.

The visits are part of a consortium-based Outreach program that's netted health and mental health support for more than 250 students and family members in rural Sandusky County, where increased unemployment and poverty in recent years have taken a toll.

"The children and youth are being hit especially hard by the county's economic difficulties," says Jeanne Seeberger, chairman of the new Sandusky County Health Consortium. "And the schools — as they are all over the nation — are often the social locus of that impact."

Accordingly, the Fremont City School District, the Sandusky Valley Center (for mental health), and Community and Rural Health Services are collaborating to bring more resources to the schools and the students.

"We wanted to be able to deal with students who are at risk in a more immediate, family-centered way," says Seeberger.

The Outreach-funded project makes the schools the major help-site, offering private counseling for students and their families during both daytime and evening hours in a special mobile unit set up on schoolgrounds.

Seeberger reports as many as 54 students and 48 parents have participated in more than 350 professional counseling sessions in the first five months of the program.

Students and families are also reached through the community nurse's home visits, and through a new "peer listening" program at the high school, which involves trained student assistants.

The students work shifts in the guidance office , and on request, may sit with fellow students to offer a listening ear. They are trained to refer serious problems to the guidance counselors.

"It's another access point for those students in need," says Seeberger.

Meanwhile, the community outreach nurse has made over 420 home visits. Almost 60 percent of the visits provided opportunities for health assessments or some health education for the students or their parents.

"It's been a godsend," says Fremont high school principal Earnie Jones. He says students and their families have also been referred to physicians, counselors, and other health providers.

Says Seeberger, "We've seen cases of child neglect, domestic violence, sexual abuse, drug abuse, and disease."

Looking to help students earlier in their school careers, the consortium now plans to expand the program to the seven elementary schools in the Fremont system. It will mean an opportunity to reach as many as 5,442 students, if they need help.

Project leaders say their response is one that is needed in many school districts across the nation. They're optimistic about future state support for the Sandusky program.

Closing the distance to basic care

Belying Hawaii's popular image as a luxury paradise are the tens of thousands of people in remoter areas of this state — the world's most isolated island chain — who depend on rain for drinking water and go without many goods and services, including basic health care.

Until October of '91, the only source of subsidized, low cost health care was on the island of Oahu, at five clinics within site of Honolulu. For those living on the island of Hawaii — larger than all the other islands combined — a visit to Oahu means booking a plane fare. There is no public marine transportation.

"It would be the equivalent of a $100 round-trip 'bus ticket' to the doctor's office," says Susan Maley, executive director of the Bay Clinic's new Family Health Center program, which opened in October.

Formerly operating exclusively as a family planning service in Hilo, the Bay Clinic has used Outreach funds to create full-time primary care service for the 65,000 residents of the South Hilo and Puna districts of the island.

The expansion was a response to the pleas of family planning clients — women requesting medical care for entire families. Seventy-five percent of the clients live at or below the poverty level, according to Maley. Respiratory distress from volcanic fog and from high mold and mildew levels is a common problem.

Until the clinics opened with primary care, these residents could only resort to the hospital emergency room in Hilo, a 50-mile, one-and-a-half-hour trip for many.

Today, the Family Health Center's full time physician Dr. Robert McAlister sees some 30 patients a day in Puna, or more than 500 patients a month. A nurse practitioner will also be hired. In Hilo, the service expansion begins with a half-time physician who will additionally be on-call and admit patients to the hospital.

Family planning services continue — one day a week at the Puna clinic and five days a week at the Hilo site. The goal is to reduce infant mortality, low-weight births, and teenage pregnancy. As of September 1992, the two family planning sites have seen more than 1,800 clients.

In keeping with the consortium design of the Outreach grant program, the Bay Clinic has recruited partners to work together as community drawstrings — referring residents from several directions:

A native Hawaiian outreach worker, funded by the grant and retained by the Native Hawaiian Health Organization, *Hui Maloma Ola Na Oiwi*, makes door-to-door inquiries. Now, 25 percent of those coming to the clinic are Hawaiian or part-Hawaiian.

A public health nurse from the state Department of Health provides staff training, case management, and referrals.

Nursing students at the University of Hawaii, Hilo, can do their community project work at the Bay Clinic sites.

The institutional coordination was a considerable undertaking, says Maley, but the Outreach grant gave it the jump-start.

"Now there's a kind of synergistic effect that comes from meeting together frequently," she says. "We're not only looking at the issues in front of us, we're looking at public health concerns overall.

HAWAII

"It would be the equivalent of a $100 round-trip 'bus ticket' to the doctor's office."

'Brokering' benefits for the working poor

WISCONSIN

"It's really the missing piece of the policy puzzle."

A penny of prevention is worth a dollar of cure, and it's always better to pay something on the bills. — But in Western Wisconsins' dairy region, where the farm economy has collapsed under droughts and falling milk prices, those financial maxims have not been easy to apply, especially for health care.

Farmers and small business people already overwhelmed by business debt face a shrinking private pool of health insurance, high deductibles and premiums, and complicated eligibility requirements for state and federal insurance and benefit programs.

Few in this self-reliant culture of small business families have had the time or specialized knowledge to sort through a maze of rules and appeals procedures to snare enough health coverage.

Yet private and public medical insurance is technically available to many residents, according to Mike Rust, of the Center for Public Representation in Balsam Lake. They just need benefits counseling to uncover it:

Today, with Outreach grant support, a consortium of state public health offices in rural Northwest Wisconsin is blanketing a 17-county area with just such consumer information and financial counseling. Spearheading the project is the Balsam Lake office of the non-profit, public interest law center, which tested the concept two years ago in Polk and Barron counties.

"It's really the missing piece of the policy puzzle," says project director Rust, of the benefits advocacy. Now at public health sites throughout Wisconsin's Western Region, as well as one community health center and a head start program, there are financial files to accompany medical files.

Counselors conduct detailed interviews with families to study their health care bills and their benefit situation. Staffers at public health offices are being trained in appropriate sources of public and private financing.

In many cases, clients get help filing appeals with private insurers for mistakes or claim denials. "We are as successful in recovering from private insurance as we are from public sources," says Rust.

On the other hand, he says, many rural families are surprised to learn that certain members (children under 18, those over 65, pregnant women or the blind and disabled) are eligible for assistance under Medicaid — especially in cases where they were once denied.

The fact that public benefit programs are administered through local government offices increases the likelihood of error or inconsistencies, according to Rust.

Also, he says, "we're finding whole chunks of law" that are often neglected. For example, working families with just enough income to disqualify them for Medicaid help are learning that under a 1988 rule change, they can deduct substantial medical expenses from their calculated income.

Now other clinics are hiring project staff to train their credit staff. Rust says the counseling model is applicable elsewhere and could help hospitals recover funds.

Appealing to cost recovery, in fact, the Outreach program also operates a preventive care program for underinsured children in the 17-county area. Contracting with some 350 area providers — private clinics, dentists, eye doctors, and general practitioners, "KIDS CARE" has arranged for preventive care and some follow-up treatments for over 400 children by paying the providers at Medicaid rates.

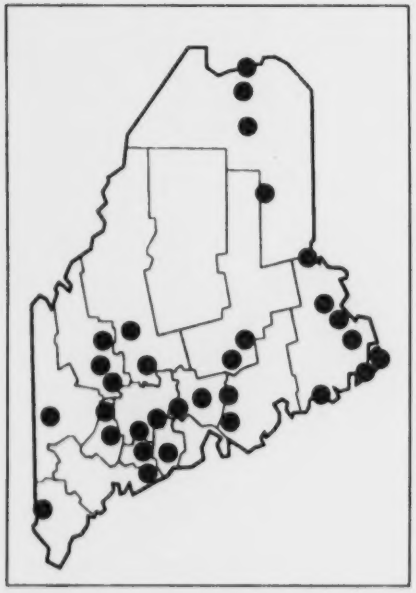
The outcome, says Rust, is that parents get over the hurdle of financial procrastination, and local providers who worry about facing a disproportionate practice of "slow or no pay" patients, can also relax and "get the job done."

All in all, says Rust of the Outreach effort, "we're discovering that we're able to secure eligibility and health care for just an amazing number of families with children."

BEST COPY AVAILABLE

Overcoming isolation for physicians

MAINE



Physician Cynthia Robertson likes the collaborative nature of practicing in a community health center, but the ability of such centers to overcome a practitioner's isolation is sorely taxed in Maine.

A largely rural state with mountainous terrain and harsh winters, Maine has some 28 community health centers serving more than 140 remote and hard-pressed rural communities. Yet the ability to maintain that care is seriously eroded by the difficulty of persuading physicians to remain in such isolated areas.

But thanks to a new telecommunications network developed with Outreach funds, the community health centers are now linked into a program of regular contact with one another in a newly-created consortium that includes two residency programs.

As a result, Dr. Robertson's daily pool of consultative partners has grown from two (on-site) to more than fifty. The network's basic tools are simple enough — fax machines and speaker phones — but they help give the providers what they need most: consultations with one another, and regular opportunities to update their learning.

The *Maine Rural Health Center Physician Support Network* was created in October of '91 by the state's primary care association (the Maine Ambulatory Care Coalition), its 28-member centers, the Maine-Dartmouth Family Practice Residency and the Eastern Maine Medical Center Family Practice Residency.

Designed to replicate the strong support system which medical schools cultivate, and doctors in urban practice enjoy, Maine's new rural network is now hummingover a 33,000 square mile area with teleconference courses and consultations.

The fax machine recently delivered a hospital EKG for one of Dr. Wilson Eastman's patients in Livermore Falls, for example, and he was able to avoid dropping a half day's patient schedule to get to the hospital.

The network, meanwhile, is offering both formal credit courses and informal symposiums by teleconference. For individual practitioners, the residencies have also created intensive courses when the need arises.

Playing a pivotal role in the new network is *locum tenens* support in which a "rural practice fellow," provided by the National Health Service Corps, pinch hits on a rotating basis for clinic doctors needing a short break. Familiar with the various clinics, the fellow is also instrumental in designing the network's continuing medical education courses.

"I found it a luxury to observe other physicians, which rarely if ever happens," says Dr. Roger Condit of the Franklin Family Health Center in Farmington, Maine. Thanks to the *locum tenens* arrangement, he was able to take a two-week "mini-residency" with Maine-Dartmouth. He had taken his original training more than twenty years ago, before the advent of family practice residencies.

The consortium is working toward preceptorships at the clinics for the family practice residents — a move that could give students exposure to rural practice, and some day pay off in more rural placements.

"We're all working so closely together that sometimes it's hard to say exactly who does what," says Post of all the reciprocity.

"We're all working so closely together that sometimes it's hard to say exactly who does what."

Putting mental health in the town plan

NEW MEXICO

"We decided we had to take ownership of the problems before we could take ownership of the solutions."

A lack of power over their lives and the life of their town is the biggest dilemma for the 3,100 residents of Navajo, New Mexico. So they began in October of '91 to wrestle its destructive consequences to the ground.

Using an Outreach grant, they established "New Ways - New Hope," a mental health program to combat local alcohol and drug abuse, sexual abuse, and domestic violence. In the first six months, the program attracted 375 participants.

"We decided we had to take ownership of the problems before we could take ownership of the solutions," says New Ways project director, Louis Kolker.

The long range "*solution*" residents want is some self-governance. Formed as a 'company town' in 1958 for the Navajo Forest Products Industries, the township has no local government. Decisions affecting residents' lives are made in Arizona by tribal leaders, or in New Mexico by government agencies, or by the Forest Products Board.

In 1989 tribal and Forest Products representatives, along with school and church interests, formed a community development corporation to revitalize Navajo and move it toward self-governance.

The "*problems*" confronting the corporation, however, are 80-85 percent alcoholism and 33 percent high school drop-out rates.

"We started looking at these horrifying statistics," says Kolker, "and decided if this community is going to take ownership of its future, it's got to heal itself first."

An Outreach grant enabled the corporation to develop the mental health program by forming a consortium with Rehoboth/McKinnley Christian Hospital in Gallup, New Mexico; Battered Family Services, a private non-profit organization; and the Phoenix-based Caribou Institute — all dubbed "The Frog Rock Consortium," after a local landmark.

Using intensive personal counseling and group seminars, the program incorporates Native American culture into modern techniques of mental health therapy, according to Kolker.

The program also includes weekly community gatherings and intervention workshops.

Many residents are Navajos who grew up away from their tribal homes in institutions, says Kolker, and the mentoring they missed as children, is a critical step toward self-empowerment.

The personal growth workshops managed by the Caribou Institute were originally developed in British Columbia for Native Americans. In keeping with the new strategy of local empowerment, the consortium is working on a plan to train Navajo's own people to administer the workshops.

Also in the interest of local decision making, the consortium decided early in March to move its administrative management from Gallup to Navajo.

Eventually, residents hope to deal with issues of housing, schools and social services.

BEST COPY AVAILABLE

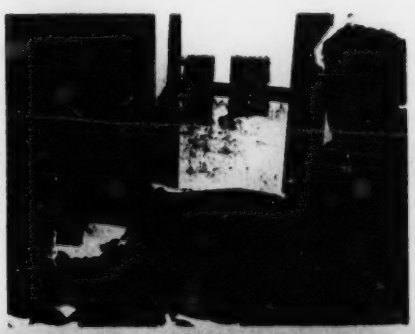
Linking care and caring for the rural elderly

Poverty, lack of transportation, and a shortage of physicians accepting Medicare and Medicaid have all conspired to keep many of Northeast Oklahoma's rural elderly stranded.

They're not only isolated in a land cut by lakes and rivers, they're stranded from many health-related services by the very fragmented nature of unconnected programs. The unmet needs, meanwhile, range from emergency meal services and day care programs, to mental health assistance and routine check-ups.

Today that is changing, as five agencies based in Muskogee and Wagoner counties have formed an Outreach consortium to address the problems. Called the "Alternative Health Care Project," the consortium is working with another 10 affiliates in the area to knit the region's elderly services together, and add some stop-gap service to meet crises.

The hub of the project is the "Circle of Love Elder Day Care" program, a private, non-profit adult day care center in Muskogee, which combines recreation and medical care for impaired older adults.



"We started out in adult day care, but we've really become a community consortium," says project director, Brenda Mahoney. She says day care is ideal for coordinating all kinds of services because residents are there for 10 hours a day:

"They can receive skilled nursing care, two meals with a third sent home, shots, emotional support, and recreation — all for $25 a day, or $35 if you want to break even," she says.

Until Outreach, there was an 18-month waiting list for the popular day care program. Today, with transportation added, the center has tripled the number of residents it serves, and it operates in Wagoner, as well as Muskogee County.

Residents need not be enrolled in day care, however, to receive other consortium services: The departments of human services in Muskegee and Wagoner counties administer Medicaid, food stamps and other entitlement programs for the aged.

Federal programs such as Meals-on-Wheels, Senior Citizens Transit, and homemaker services are administered by Eastern Oklahoma's Area Agency on Aging.

The local Goodwill Industries maintains a registry of geriatric caregivers; while a fifth partner, the joint Muskogee and Wagoner County health department "Eldercare" program, offers case evaluations, management and referral.

"We all serve on each other's advisory boards," says Mahoney. "And once a month there's a luncheon."

Key to integrating services is the new 1-800 telephone line. Elderly residents need only know the phone number, not the labyrinth of agencies. An average of 25 callers are referred each month. They're screened to make sure other options are not available, but with waiting lists for many programs, the consortium does a lot of crisis intervention.

A physician is now on contract with the center to provide five hours a week for emergency services and consultations. A new geriatric specialist based at the center makes home visits within a 30-mile radius to offer mental health support.

The area's temporary home health aides and homemaking and chore services have also been expanded.

A new van and a wide-door car provide some short-notice trips to medical appointments, as well as transportation to the day care program.

While 200 emergency meal deliveries a month were planned by the project, volunteers are now delivering closer to 1,200.

"We've picked up the pieces," says Mahoney, an RN who has worked with the elderly for 24 years. "But I think we've just started chipping away at the need."

She estimates they're reaching fewer than a fourth of the area's frail elderly so far. But the rewards, she says, are widespread: "It's a whole community, joining hands, giving and taking love."

OKLAHOMA

"We started out in adult day care, but we've become a community consortium."

Tracking moms and 'healthy babies'

ALABAMA

"I'm just amazed at being able to reach so many people."

Expectant mothers in Alabama's DeKalb and Cherokee counties used to wait up to six hours to be seen at the local health department clinic. Today they wait no more than one hour, and their progress and their babies' progress are charted by computer for up to five years after delivery.

The change is the outcome of the Healthy Babies project in this northeastern section of Alabama, a state whose rural areas are experiencing high rates of infant death and illness.

The centralized recordkeeping at the DeKalb Baptist Medical Center hospital in Fort Payne is just one of several ways that the Outreach-financed project works. Initiated through the Medical Center, it coordinates the resources of two county health departments, a private obstetrical practice, as well as the hospital— all told, four full-time nurses, a social worker, and a van driver available to promote better prenatal care.

The project purchased a 15-passenger van to overcome the transportation problems of the area's rural clients, so they can reach the clinic and also participate in education classes. Prenatal classes at the state health department in DeKalb are now heavily attended, and the hospital's own classes have quadrupled, according to project director and hospital administrator Jeff Brewer.

The hospital's registered nurses are also conducting health education in the schools to combat teen pregnancy. "The acceptance by the schools and the students has been phenomenal," says the project's coordinator Kathy McClung.

Another facet of the project draws upon the public health department for environmental assessments of homes. So far, staffers have investigated 13 cases of possible health hazards, finding six homes with contaminated well water. At one location, outreach staffers found a mother and a newborn living in a car. The project's newly-funded social worker was able to relocate the pair, says McClung.

Nearby Jefferson County has joined with DeKalb and Cherokee counties to help fund a training seminar for staff dealing with their clients' social and psychological needs. "One of the lasting benefits of this project is that all of this training is going to people who are permanent residents of the community," says Brewer.

Healthy Babies augments its professional staff effort with some 20 volunteers — lay advisors in the community who encourage other women to seek care and who provide support and referrals.

Today, *Healthy Babies* can measure its reach by the number of records in its computer — more than 300 created in the first six months.

"I'm just amazed," says McClung, who has spent six years in prenatal education in DeKalb County, "at being able to reach so many people."

Rural Americans share many of the same problems but each community is unique.

Reflecting that diversity are the 100 projects funded under the Rural Health Outreach Grant Program. Their strategies are tailored to fit the special needs of the people they serve. Successful programs require dedicated, visionary people.

Each story is different. Each is worth telling.

100 STORIES

Southeast Alaska Regional Health Corp
Sitka, AK

Washington County Health Department
Chatom, AL

Baptist Medical Center DeKalb
Fort Payne, AL

St. Francis Area Development Center
Forrest City, AR

Casa Grande Regional Medical Center
Casa Grande, AZ

Mariposa Community Health Center, Inc.
Nogales, AZ

White Mountain Communities Hospital
Springerville, AZ

County of Madera
Madera, CA

San Benito Health Foundation
Hollister, CA

Tuolumne County
Sonora , CA

Redwood Coast Seniors, Inc.
Fort Bragg, CA

The Resource Center, Inc.
Grand Junction, CO

Putnam County Public Health Unit
Palatka, FL

Grady General Hospital
Cairo, GA

Dorminy Medical Center
Fitzgerald, GA

Southwest GA Comm. Action Council
Moultrie, GA

The Bay Clinic, Inc.
Hilo, HI

Grundy County Memorial Hospital
Grundy Center, IA

Mahaska County Hospital
Oskaloosa, IA

South Central District Health Dept.
Twin Falls, ID

Terry Reilly Health Services
Nampa, ID

Kootenai Medical Center
Coeur D'Alene, ID

LaSalle County Health Department
Ottawa, IL

The Douglas-Moultrie Rural Health Board
Tuscola, IL

Farm Resource Center, Inc.
Cairo, IL

Community Mental Health Center,
Ripley County
Osgood, IN

Reno County Health Department
Hutchinson, KS

Eastern Kentucky University
Richmond, KY

Avoyelles Technical Institute
Cottonport, LA

Franklin County Commission
Greenfield, MA

S.C.O.P.E., Inc.
Princess Anne, MD

Maine Ambulatory Care Coalition
Manchester, ME

Kennebec Valley Regional Health Agency
Waterville, ME

Blue Hill Memorial Hospital
Blue Hill, ME

Thunder Bay Family Medical Clinic
Hillman, MI

Sault Ste. Marie Tribe of Chippewa Indians
Sault Ste. Marie, MI

Menominee County Community Mental
Health Board
Menominee, MI

Baldwin Family Health Care, Inc.
Baldwin, MI

St. Joseph's Medical Center
Home Care Department
Brainerd, MN

Multi-County Nursing Service
Detroit Lakes, MN

Ozarks Medical Center
West Plains, MO

Howard County Human Services Council
Fayette, MO

City of Vicksburg, Mississippi
Vicksburg, MS

Southwest Health Agency for Rural People
Tylertown, MS

Critical Illness & Trauma Foundation
Big Timber, MT

Migrant Benevolent Association, Inc.
Newton Grove, NC

Robeson Health Care Corporation
Pembroke, NC

North Dakota Assn of EMTs/ECTs
Cooperstown, ND

Stanley Community Hospital
Stanley, ND

Blue Valley Community Action, Inc.
Fairbury, NE

Panhandle Community Services
Gering, NE

Trustees of Dartmouth College,
Dartmouth Medical School
Hanover, NH

Navajo Townsite
Community Development Corporation
Navajo, NM

La Clinica del Pueblo de Rio Arriba
Tierra Amarilla, NM

Nevada Home Health Services
Elko, NV

Salamanca Hospital District Authority
Salamanca, NY

State University of New York
Alfred, NY

Community Action Commission of Fayette Co.
Wash. Court House, OH

Community & Rural Health Services
Fremont, OH

Henry County-Napoleon City
Combined General Health District
Napoleon, OH

Southern Consortium for Children
Athens, OH

Circle of Love Elder Day Care LTD.
Muskogee, OK

Konawa Community
Health Improvement Association
Konawa, OK

La Clinica Del Carino
Hood River, OR

Columbia County Community Health, Inc.
St. Helens, OR

Tillamook County
Tillamook, OR

Health Care Coalition of Southern Oregon
Cave Junction, OR

Eastern Oregon Human Services
Consortium
La Grande, OR

Northwest Pennsylvania Regional
Planning & Development Commission
Franklin, PA

Palau Community Action Agency
Koror, PW

Britton's Neck Health Care Association, Inc.
Conway, SC

Barnwell County Hospital
Barnwell, SC

University of South Dakota
School of Medicine
Vermillion, SD

Lewis & Clark Health, Education
& Service Agency
Yankton, SD

Sacred Heart Hospital
Yankton, SD

Isabel Community Clinic, Inc.
Isabel, SD

Oglala Sioux Tribe Head Start Program
Porpupine, SD

Hancock County Medical Clinic
Sneedville, TN

Meridian Hospital Authority
Meridian, TX

Gonzales County Health Agency, Inc.
Gonzales, TX

South Plains Health Provider
Organization, Inc.
Plainview, TX

South Plains Public Health District
Brownfield, TX

Duchesne County Hospital
Roosevelt, UT

San Juan Hospital
Monticello, UT

Blue Ridge Health Center, Inc.
Arrington, VA

Eastern Shore Rural Health Systems, Inc.
Onancock, VA

St. Charles Health Council, Inc.
St. Charles, VA

Saltville Health Center Commission,
Saltville Medical Center
Saltville, VA

Virgin Islands Department of Health
St. Thomas, VI

Copley Hospital, Inc.
Morrisville, VT

Klickitat-Skamania Development Council
White Salmon, WA

Metaline Falls Community Hospital Association
Metaline Falls, WA

Northern Health Centers, Inc.
Lakewood, WI

St. Mary's Hospital
Sparta, WI

Tomah Memorial Hospital, Inc.
Tomah, WI

Center for Public Representation
Balsam Lake, WI

Mercer Health Right, Inc.
Bluefield, WV

Monongalia County Health Department
Morgantown, WV

Preston Memorial Hospital, Inc.
Kingwood, WV

Sheridan County Public Health
Sheridan, WY

Photo: U.S. Department of Agriculture

RURAL FACTS OF LIFE

Fewer than half as many physicians practice in rural America as in urban America.

Ten percent of all rural hospitals closed in the past decade. Emergency medical services are threadbare or absent in many locales.

For the first time in our history, the rural poverty rate is higher than the national poverty rate, and increasing.

Rural residents have higher rates of unemployment than urban residents.

Rural Americans are much more likely to be uninsured or underinsured than urban Americans.

Rural residents have higher rates of chronic or serious illness than urban Americans.

Homelessness, suicide, domestic violence, child abuse, alcoholism and drug abuse are all on the rise, especially in economically depressed areas.

A high level of depression is pervasive among rural adolescents, and suicide rates for rural teens are high.

HIV/AIDS in rural areas is also increasing.

Poverty among black Americans living in rural areas is even greater than in cities, since nearly half have incomes below the poverty line.

Farming rivals mining (also a principal rural industry) as the nation's most dangerous occupation. Yearly, it claims more than 1,500 lives.

For injuries, agriculture is second to none. Some 23,500 children, alone, are maimed or disabled each year on farms and ranches.

From U.S. Department of Agriculture

"Now there's a kind of synergistic effect that comes from meeting together frequently. We're not only looking at the issues in front of us, we're looking at public health concerns overall."

— Susan Maley
The Bay Clinic, Hilo

For information about Outreach, contact:

Federal Office of Rural Health Policy
Parklawn Building, Room 9-05
5600 Fishers Lane
Rockville, Maryland 20857
Telephone: (301) 443-0835